Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: OXMED INC PO BOX 972557 DALLAS TX 75397-2557	MFDR Tracking #: M4-04-1546-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO. Box #: 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "We feel that we are due full and total reimbursement for the equipment provided to this patient. The carrier has incorrectly viewed this claim and has paid it at a reduced rate. We have provided the carrier with examples of payments made in full. This claim item was submitted based on the 1991 Fee Guidelines and should have been paid accordingly. We the provider are now requesting **Full** reimbursement for the item billed with accruing **interest.**"

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Total Amount Sought - $220.13

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "…the Texas Mutual believes it has shown its method of determining fair and reasonable reimbursement, the same method that the Texas Mutual uses consistently and has documented its claim file in compliance with 133.304(i). The Texas Mutual states again for all parties to hear that the requestor has never, that the Texas Mutual knows of, given a monetary reason, explanation, or rationale why 100% of billed charges is a fair and reasonable payment. Consequently, it is the Texas Mutual's position no additional payment can be made to the requestor's DME items until the requestor clearly demonstrates its charges are a fair and reasonable payment for the items in Texas or that the Texas Mutual's payment is not fair and reasonable."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
5/5/03	M, RD, O, YO	E0781	$220.13	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background.

1. This request for medical fee dispute resolution was received by the Division on October 6, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, applicable to disputes filed on or after January 1, 2003, the

Division notified the requestor on October 10, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, DURABLE MEDICAL EQUIPMENT (DME) GROUND RULE IX. A, titled Billing, states that "A statement of medical necessity, along with the order or prescription appropriate for the equipment/supplies shall accompany initial claims for the rental or purchase of DME. Any verbal order given by the doctor to the DME provider shall be followed by a written prescription or order prior to billing for the DME equipment/supplies."
5. Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, DURABLE MEDICAL EQUIPMENT (DME) GROUND RULE IX. C, titled Billing, states that "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline."
6. Division rule at 28 TAC §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue."
7. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement."
8. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 6/17/2003

   - M, YM-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D).

   Explanation of benefits dated 9/15/2003

   - M, RD-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(B).
   - O, YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed.

Issues

1. Was the dispute filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307?
2. What is the applicable rule for reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor's position for each disputed fee issue. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(C)(iv).
2. Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated between the provider and carrier for the disputed HCPCS codes; therefore, the insurance carrier

shall reimburse the provider the fair and reasonable rate for the item described per Division rule at 28 TAC §134.201 DME GROUND RULE IV.

HCPCS code E0781 is described as "Ambulatory infusion pump, single or multiple channels, with administrative equipment, worn by the patient." Division rule at 28 TAC §134.201, DME GROUND RULE IX, C, titled Billing states that a fair and reasonable rate will be the fees set in the 1991 MFG. A review of the 1991 MFG does not contain a HCPCS code for "Ambulatory infusion pump, single or multiple channels, with administrative equipment, worn by the patient;" therefore, this service shall be reimbursed at a fair and reasonable rate pursuant to Division rule at Division rule at 28 TAC §134.1 and Texas Labor Code §413.011..

3. Division rule at 28 TAC §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's rationale for increased reimbursement from the Table of Disputed Services states that We feel that we are due full and total reimbursement for the equipment provided to this patient. The carrier has incorrectly viewed this claim and has paid it at a reduced rate. We have provided the carrier with examples of payments made in full. This claim item was submitted based on the 1991 Fee Guidelines and should have been paid accordingly. We the provider are now requesting **Full** reimbursement for the item billed with accruing **interest.**"
   - The requestor does not discuss or explain how additional payment of $220.13 for HCPCS E0781 would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

   The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

ORDER:

		May 27, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.